NAMI Connecticut
National Alliance on Mental Illness
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Testimony of NAMI Connecticut (National Alliance on Mental Illness)
Before the Insurance and Real Estate Committee
March 5, 2019

In support of:

HB 7125—An Act Concerning Parity for Mental Health and Substance Use Disorder Benefits, Non-Quantitative Treatment Limitations, Drugs Prescribed for the Treatment of Substance Abuse Disorders, and Substance Abuse Services.

Good afternoon Senator Lesser, Representative Scanlon, and members of the Insurance and Real Estate Committee. Thank you for the opportunity to provide testimony to your committee on the above referenced raised bills. My name is Susan Kelley, and I am statewide Director of Advocacy and Policy for NAMI Connecticut. NAMI Connecticut is the state chapter of national NAMI, the largest grassroots mental health organization dedicated to building better lives for all those affected by mental health conditions. NAMI Connecticut provides mental health support, education, and advocacy for children, families, and adults in the state impacted by mental health conditions. I also lead NAMI Connecticut's children's mental health policy program, the Alliance for Children's Mental Health (ACMH). ACMH is a collective advocacy group comprised of a broad spectrum of state stakeholders focusing on children's mental health issues, including the critical overlap of mental health with child-serving systems of education, child welfare, and juvenile justice. I am here today to testify in support of HB 7125 on behalf of NAMI Connecticut and ACMH.

We strongly support the general intent of HB 7125 which would ensure health insurers' compliance of state and federal mental health parity laws, but are requesting that substitute language be used. Congress enacted the federal Mental Health Parity and Addiction Equity Act (MHPAEA) in 2008. This law establishes that when large insurers' (50 or more employees) provide benefits for both mental health and medical care, the coverage and benefits for each must be treated equally. MHPAEA applies to both health carriers and self-insured plans. Connecticut also has an existing mental health parity law which requires that individual, small group, and large group health plans provide coverage of diagnosis and treatment of mental health conditions. (See CGA Sections 38a-488a; 38a-514)

The substituted language we are requesting follows the bill's current language and adds provisions concerning reporting of Non-Quantitative Treatment Limitations (NQTLs). See attached substituted bill language. These additional provisions require reporting of all necessary steps demonstrating that plans and insurers are applying NQTLs to mental health and substance use benefits no more strictly than they do for other medical care benefits. *See attached examples of NQTL limitations.*

HB 7125, with the substituted language, is necessary to ensure that state insurance carriers comply with MPHAEA and Connecticut parity laws. Currently there are no means to enforce compliance such as through audits or other actions. This bill, would among things, require insurance carriers to submit an annual report demonstrating compliance and the holding of an annual public hearing on the report. These particular requirements are essential to obtaining necessary information demonstrating compliance, transparency regarding insurers' basis for determining whether they are in compliance, and public input on the insurers' report and the state's response to the report. *Public input is necessary because of the substantial numbers of insured people in the state who have been negatively impacted as a result of ongoing disparities in access to affordable mental health treatment. These individuals and families and the general public must be included as an integral part of the state's efforts to ensure parity in health insurance is being achieved.*

Importantly, HB 7125, with the substituted language, is based on the model bill regarding mental health parity that has been used successfully in many states, including Washington DC, Delaware, Illinois, Tennessee, and is currently being considered in 15-20 states, including Massachusetts. Mental health advocates listened to insurers' concerns about last year's bill, such as lengthy data reporting requirements and lack of uniformity with other state requirements. *The model bill is a much simpler version of last year's bill. Using the model approach will help standardize parity requirements nationwide, making compliance easier for health insurance companies which often operate in several states.*

HB 7125 boils down to something very simple: state and federal law mandates that mental health insurance coverage cannot be treated any differently than medical coverage, and we need this proposed law to make parity a reality for the many individuals and families in the state who need access to affordable mental health treatment.

You will hear many individuals testify today who have experienced significant disparities in their out of pocket costs and ability to access mental health services as compared to for medical care. My family has also experienced this unfairness, costing us thousands of dollars. Our 21 year old son has significant anxiety and depression challenges. He has been going to therapists and psychiatrists since he started high school. Rarely has he been able to find mental health clinicians who either take insurance (due to lower reimbursement rates as compared to medical doctors) or are in network. Fortunately, he continued to get treatment because we could afford the extra costs. This is not the case for many insured families who go without care for their child or themselves because they can't afford to pay steep out of pocket mental health care costs. This inability to access affordable mental health care leads to increased health care costs for the state, such as through crisis interventions and trips to the ER, and poorer human health outcomes.

Our son's experience mirrors the national survey results described by NAMI in its 2107 report regarding the continuing disparities between mental and physical health providers in health insurance. The NAMI report found:

- *Searching for a provider:* Nearly 35% of respondents with private insurances reported difficulties finding *any* mental health therapist who would accept their insurance.

- *Out-of-network care:* 28% of respondents who received psychotherapy used an out-of-network provider. In contrast, only 7% of respondents used an out-of-network medical specialist and only 3% used an out-of-network primary care provider.
- *Out-of-pocket costs:* Out-of-pocket costs exceeding $200 were over 1.5 times more frequent for mental health therapists (15%) and psychiatric prescribers (16%) compared to medical specialty care (9%).[1]

Similarly, in the same year, Milliman Inc., a national consulting firm issued its report on behalf of a nationwide coalition of leading mental health and addictions advocacy organizations which "validates what NAMI's surveys have shown: people must seek mental health care out-of-network much more frequently than for other health care." [2]

For all of these reasons, we support moving forward HB 7215 using the attached substituted bill language, and ultimate passage of this bill to achieve mental health parity in insurance for Connecticut individuals, children, and families.

Thank you for your attention to my testimony. I would be happy to answer any questions you may have.

Respectfully submitted,

Susan R. Kelley
Director of Advocacy and Policy
NAMI Connecticut

[1] NAMI Report, The Doctor is Out, Continuing Disparities Between Mental and Physical Health Providers in Health Insurance, Nov. 30, 2017, https://www.nami.org/About-NAMI/Publications-Reports/Public-Policy-Reports/The-Doctor-is-Out

[2] https://www.nami.org/Press-Media/Press-Releases/2017/NAMI-Releases-Parity-Report-Which-Finds-Insurance

What Does a "Parity" Problem Look Like?

Below is a hypothetical but realistic example showing the disparity between how insurers cover medical treatment versus how they cover behavioral health treatment.

Insurer Coverage of Cardiac Treatment

Dave has heart disease and had suffered two previous near-fatal heart attacks. After each heart attack Dave was transferred to an inpatient cardiac rehab facility. He just had another heart attack and was admitted to the emergency department. After Dave was stabilized, the emergency department recommended he be transferred to an inpatient cardiac rehab facility. Dave's insurance plan, operated by the ACME Insurance company, requires prior authorization before a patient can be admitted to an inpatient, in-network cardiac rehab facility. The facility submitted the claim for prior authorization. A utilization reviewer for ACME performed the prior authorization process. The reviewer called the attending physician at the rehab facility and spoke with her for ten minutes. The physician stated that Dave met the criteria for inpatient rehab admission specified in the Guidelines of the American College of Cardiology. The utilization reviewer approved the claim with further authorization required after 14 days.

Insurer Coverage of Behavioral Health Treatment

Dan has an opioid use disorder and had suffered two near-fatal opioid overdoses. After each overdose Dan was transferred to an inpatient residential treatment facility. He just experienced another overdose and was admitted to the emergency department. After Dan was stabilized, the emergency department recommended that he be transferred to an inpatient residential treatment facility. Dan's insurance plan, operated by the ACME Insurance Company, requires prior authorization before a patient can be admitted to an inpatient, in-network residential treatment facility. The facility submitted the claim for prior authorization. A utilization reviewer for ACME performed the prior authorization process. As part of the prior authorization the attending physician from the treatment facility was required to submit a written treatment plan that detailed clear benchmarks for how recovery would be established and progress requirements by certain dates. The reviewer called the attending physician and spoke with her for 45 minutes. The attending physician stated that Dan met the criteria for inpatient residential treatment as specified in the Patient Placement Guidelines of the American Society of Addiction Medicine. The reviewer noted that Dan had already been in a residential facility before yet had relapsed and overdosed and wondered why this time would be any different. The utilization reviewer then required the attending physician to submit to a peer clinical review and then an expert review before the prior authorization process was completed. This consisted of two additional phone calls, each lasting 30 minutes. Ultimately the utilization reviewer approved the claim but with further authorization required after two days.

General Assembly

Raised Bill No. 7125

January Session, 2019

LCO No. **4074**

Referred to Committee on INSURANCE AND REAL ESTATE

Introduced by:
(INS)

AN ACT CONCERNING PARITY FOR MENTAL HEALTH AND SUBSTANCE USE DISORDER BENEFITS, NONQUANTITATIVE TREATMENT LIMITATIONS, DRUGS PRESCRIBED FOR THE TREATMENT OF SUBSTANCE USE DISORDERS, AND SUBSTANCE ABUSE SERVICES.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. (NEW) (*Effective October 1, 2019*) (a) For the purposes of this section:

(1) "Health carrier" has the same meaning as provided in section 38a-1080 of the general statutes;

(2) "Mental health and substance use disorder benefits" means all benefits for the treatment of a mental health condition or a substance use disorder that (A) falls under one or more of the diagnostic categories listed in the chapter concerning mental disorders in the most recent edition of the World Health Organization's "International Classification of Diseases", or (B) is a mental disorder, as that term is defined in the most recent edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders";

and

(3) "Nonquantitative treatment limitation" means a limitation that cannot be expressed numerically but otherwise limits the scope or duration of a covered benefit.

(b) Not later than March 1, 2021, and annually thereafter, each health carrier shall submit a report to the Insurance Commissioner, Attorney General, Healthcare Advocate and executive director of the Office of Health Strategy, in a form and manner prescribed by the Insurance Commissioner, containing the following information for the calendar year immediately preceding:

(1) A description of the processes that such health carrier used to develop and select criteria to assess the medical necessity of (A) mental health and substance use disorder benefits, or (B) medical and surgical benefits;

(2) A description of all nonquantitative treatment limitations that such health carrier applied to (A) mental health and substance use disorder benefits, and (B) medical and surgical benefits; and

(3) The results of an analysis concerning the processes, strategies, evidentiary standards and other factors that such health carrier used in developing and applying the criteria described in subdivision (1) of this subsection and each nonquantitative treatment limitation described in subdivision (2) of this subsection. The results of such analysis shall, at a minimum:

(A) Disclose each factor that such health carrier considered, regardless of whether such health carrier rejected such factor, in (i) designing each nonquantitative treatment limitation described in subdivision (2) of this subsection, and (ii) determining whether to apply such nonquantitative treatment limitation;

(B) Disclose the evidentiary standards that such health carrier applied in considering the factors described in subparagraph (A) of

this subdivision; ~~and~~

(C) Provide the comparative analyses, including the results of the analyses, performed to determine that the processes and strategies used to design each nonquantitative treatment limitation, as written, and the as written processes and strategies used to apply the nonquantitative treatment limitation to mental health and substance use disorder benefits are comparable to, and are applied no more stringently than, the processes and strategies used to design each nonquantitative treatment limitation, as written, and the as written processes and strategies used to apply the nonquantitative treatment limitation to medical and surgical benefits;

(D) Provide the comparative analyses, including the results of the analyses, performed to determine that the processes and strategies used to apply each nonquantitative treatment limitation, in operation, for mental health and substance use disorder benefits are comparable to, and are applied no more stringently than, the processes or strategies used to apply each nonquantitative treatment limitation, in operation, for medical and surgical benefits; and

(~~C~~E) Disclose information that, in the opinion of the Insurance Commissioner, is sufficient to demonstrate that such health carrier (i) equally applied each nonquantitative treatment limitation described in subdivision (2) of this subsection to (I) mental health and substance use disorder benefits, and (II) medical and surgical benefits, and (ii) complied with (I) sections 2 and 3 of this act, (II) sections 38a-488a and 38a-514 of the general statutes, and (III) the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, P.L. 110-343, as amended from time to time, and regulations adopted thereunder.

(c) Not later than March 15, 2021, and annually thereafter, the Insurance Commissioner shall submit, in accordance with section 11-4a of the general statutes, to the joint standing committee of the General Assembly having cognizance of matters relating to insurance each

report that the commissioner received pursuant to subsection (b) of this section for the calendar year immediately preceding.

(d) Not later than April 1, 2021, and annually thereafter, the joint standing committee of the General Assembly having cognizance of matters relating to insurance shall hold a public hearing concerning the reports that such committee received pursuant to subsection (c) of this section for the calendar year immediately preceding. The Insurance Commissioner, Attorney General, Healthcare Advocate and executive director of the Office of Health Strategy, or their designees, shall attend the public hearing and inform the committee whether, in their opinion, each health carrier, for the calendar year immediately preceding, (1) submitted a report pursuant to subsection (b) of this section that satisfies the requirements established in said subsection, and (2) complied with (A) sections 2 and 3 of this act, (B) sections 38a-488a and 38a-514 of the general statutes, and (C) the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, P.L. 110-343, as amended from time to time, and regulations adopted thereunder.

(e) The Insurance Commissioner may adopt regulations, in accordance with chapter 54 of the general statutes, to implement the provisions of this section.

Sec. 2. (NEW) (*Effective January 1, 2020*) No individual health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of the general statutes delivered, issued for delivery, renewed, amended or continued in this state shall apply a nonquantitative treatment limitation to mental health and substance use disorder benefits unless such policy also applies the nonquantitative treatment limitation to medical and surgical benefits. For the purposes of this section, "nonquantitative treatment limitation" and "mental health and substance use disorder benefits" have the same meaning as provided in section 1 of this act.

Sec. 3. (NEW) (*Effective January 1, 2020*) No group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of the general statutes delivered, issued for delivery, renewed, amended or continued in this state shall apply a nonquantitative treatment limitation to mental health and substance use disorder benefits unless such policy also applies the nonquantitative treatment limitation to medical and surgical benefits. For the purposes of this section, "nonquantitative treatment limitation" and "mental health and substance use disorder benefits" have the same meaning as provided in section 1 of this act.

Sec. 4. (NEW) (*Effective January 1, 2020*) (a) Each individual health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11), (12) and (16) of section 38a-469 of the general statutes delivered, issued for delivery, renewed, amended or continued in this state that provides coverage for prescription drugs shall provide coverage for each prescription drug that is prescribed to a person covered under such policy for the treatment of a substance use disorder, provided use of such drug for such treatment is in compliance with approved federal Food and Drug Administration indications.

(b) If an individual health insurance policy described in subsection (a) of this section includes multiple cost-sharing tiers for prescription drugs, the policy shall place each prescription drug that such policy is required to cover pursuant to said subsection in such policy's lowest cost-sharing tier for prescription drugs.

(c) No individual health insurance policy described in subsection (a) of this section shall refuse to cover a prescription drug that such policy is required to cover pursuant to said subsection solely because such drug was prescribed pursuant to an order issued by a court of competent jurisdiction.

Sec. 5. (NEW) (*Effective January 1, 2020*) (a) Each group health insurance policy providing coverage of the type specified in

subdivisions (1), (2), (4), (11), (12) and (16) of section 38a-469 of the general statutes delivered, issued for delivery, renewed, amended or continued in this state that provides coverage for prescription drugs shall provide coverage for each prescription drug that is prescribed to a person covered under such policy for the treatment of a substance use disorder, provided use of such drug for such treatment is in compliance with approved federal Food and Drug Administration indications.

(b) If a group health insurance policy described in subsection (a) of this section includes multiple cost-sharing tiers for prescription drugs, the policy shall place each prescription drug that such policy is required to cover pursuant to said subsection in such policy's lowest cost-sharing tier for prescription drugs.

(c) No group health insurance policy described in subsection (a) of this section shall refuse to cover a prescription drug that such policy is required to cover pursuant to said subsection solely because such drug was prescribed pursuant to an order issued by a court of competent jurisdiction.

Sec. 6. (NEW) (*Effective January 1, 2020*) No individual health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of the general statutes that is delivered, issued for delivery, renewed, amended or continued in this state shall refuse to provide coverage for covered substance abuse services solely because such substance abuse services were provided pursuant to an order issued by a court of competent jurisdiction.

Sec. 7. (NEW) (*Effective January 1, 2020*) No group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of the general statutes that is delivered, issued for delivery, renewed, amended or continued in this state shall refuse to provide coverage for covered substance abuse services solely because such substance abuse services were provided

pursuant to an order issued by a court of competent jurisdiction.

Sec. 8. Subsection (a) of section 38a-510 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2020*):

(a) No insurance company, hospital service corporation, medical service corporation, health care center or other entity delivering, issuing for delivery, renewing, amending or continuing an individual health insurance policy or contract that provides coverage for prescription drugs may:

(1) Require any person covered under such policy or contract to obtain prescription drugs from a mail order pharmacy as a condition of obtaining benefits for such drugs; or

(2) Require, if such insurance company, hospital service corporation, medical service corporation, health care center or other entity uses step therapy for such drugs, the use of step therapy for (A) any prescribed drug for longer than sixty days, or (B) a prescribed drug for cancer treatment for an insured who has been diagnosed with stage IV metastatic cancer, or a prescribed drug for the treatment of a substance use disorder, provided such prescribed drug is in compliance with approved federal Food and Drug Administration indications.

(3) At the expiration of the time period specified in subparagraph (A) of subdivision (2) of this subsection or for a prescribed drug described in subparagraph (B) of subdivision (2) of this subsection, an insured's treating health care provider may deem such step therapy drug regimen clinically ineffective for the insured, at which time the insurance company, hospital service corporation, medical service corporation, health care center or other entity shall authorize dispensation of and coverage for the drug prescribed by the insured's treating health care provider, provided such drug is a covered drug under such policy or contract. If such provider does not deem such step therapy drug regimen clinically ineffective or has not requested an override pursuant to subdivision (1) of subsection (b) of this section,

such drug regimen may be continued. For purposes of this section, "step therapy" means a protocol or program that establishes the specific sequence in which prescription drugs for a specified medical condition are to be prescribed.

Sec. 9. Subsection (a) of section 38a-544 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2020*):

(a) No insurance company, hospital service corporation, medical service corporation, health care center or other entity delivering, issuing for delivery, renewing, amending or continuing a group health insurance policy or contract that provides coverage for prescription drugs may:

(1) Require any person covered under such policy or contract to obtain prescription drugs from a mail order pharmacy as a condition of obtaining benefits for such drugs; or

(2) Require, if such insurance company, hospital service corporation, medical service corporation, health care center or other entity uses step therapy for such drugs, the use of step therapy for (A) any prescribed drug for longer than sixty days, or (B) a prescribed drug for cancer treatment for an insured who has been diagnosed with stage IV metastatic cancer, or a prescribed drug for the treatment of a substance use disorder, provided such prescribed drug is in compliance with approved federal Food and Drug Administration indications.

(3) At the expiration of the time period specified in subparagraph (A) of subdivision (2) of this subsection or for a prescribed drug described in subparagraph (B) of subdivision (2) of this subsection, an insured's treating health care provider may deem such step therapy drug regimen clinically ineffective for the insured, at which time the insurance company, hospital service corporation, medical service corporation, health care center or other entity shall authorize dispensation of and coverage for the drug prescribed by the insured's treating health care provider, provided such drug is a covered drug

under such policy or contract. If such provider does not deem such step therapy drug regimen clinically ineffective or has not requested an override pursuant to subdivision (1) of subsection (b) of this section, such drug regimen may be continued. For purposes of this section, "step therapy" means a protocol or program that establishes the specific sequence in which prescription drugs for a specified medical condition are to be prescribed.

Sec. 10. Section 38a-510b of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2020*):

No individual health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11), (12) and (16) of section 38a-469 delivered, issued for delivery, renewed, amended or continued in this state that provides coverage for prescription drugs [and includes on its formulary naloxone] shall require prior authorization for the following drugs if such drugs are included on the policy's formulary:

(1) Naloxone hydrochloride or any other similarly acting and equally safe drug approved by the federal Food and Drug Administration for the treatment of drug overdose; [shall require prior authorization for such drug] and

(2) Any drug approved by the federal Food and Drug Administration for the treatment of a substance use disorder.

Sec. 11. Section 38a-544b of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2020*):

No group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11), (12) and (16) of section 38a-469 delivered, issued for delivery, renewed, amended or continued in this state that provides coverage for prescription drugs [and includes on its formulary naloxone] shall require prior authorization for the following drugs if such drugs are included on the policy's formulary:

(1) Naloxone hydrochloride or any other similarly acting and equally safe drug approved by the federal Food and Drug Administration for the treatment of drug overdose; [shall require prior authorization for such drug.] and

(2) Any drug approved by the federal Food and Drug Administration for the treatment of a substance use disorder.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*October 1, 2019*	New section
Sec. 2	*January 1, 2020*	New section
Sec. 3	*January 1, 2020*	New section
Sec. 4	*January 1, 2020*	New section
Sec. 5	*January 1, 2020*	New section
Sec. 6	*January 1, 2020*	New section
Sec. 7	*January 1, 2020*	New section
Sec. 8	*January 1, 2020*	38a-510(a)
Sec. 9	*January 1, 2020*	38a-544(a)
Sec. 10	*January 1, 2020*	38a-510b
Sec. 11	*January 1, 2020*	38a-544b

Statement of Purpose:

To (1) require each health carrier to submit an annual report concerning parity for mental health and substance use disorder benefits, (2) require the joint standing committee of the General Assembly having cognizance of matters relating to insurance to conduct an annual public hearing concerning such report, (3) require nonquantitative treatment limitations to be applied equally to mental health and substance use disorder benefits and medical and surgical benefits under certain health insurance policies, (4) require health insurance coverage for (A) prescription drugs prescribed for the treatment of substance use disorders if a policy includes coverage for prescription drugs, and (B) substance abuse services regardless of whether such services were provided pursuant to a court order, and (5) prohibit mandatory step therapy and prior authorization for prescription drugs prescribed for the treatment of substance use disorders.

[Proposed deletions are enclosed in brackets. Proposed additions are indicated by underline, except that when the entire text of a bill or resolution or a section of a bill or resolution is new, it is not underlined.]

What Does a "Parity" Problem Look Like?
Below is a hypothetical but realistic example showing the disparity between how insurers cover medical treatment versus how they cover behavioral health treatment.

Insurer Coverage of Diabetes Treatment
Joan has type II diabetes and sees her endocrinologist once every three months for evaluation and management of her insulin dosage. Joan sees her nutritional counselor once a week consisting of individualized medical nutritional therapy. Joan has been hospitalized three times previously because of either an acute hyperglycemic hyperosmolar state or complications that led to toe amputations. Joan's endocrinologist noticed during her most recent visit that Jane had unusually high blood sugar levels, sudden weight gain, and mentioned that she had started been drinking soda and other high-fructose corn syrup beverages. Joan's endocrinologist feared that Joan was at risk of another acute hyperglycemic hyperosmolar state, ordered an adjustment to her insulin dosage, recommended that she see the endocrinologist weekly for the next month, and that she see her nutritional counselor twice weekly for the next month. Joan's insurance plan, operated by the Acme Health Insurance Company (AHIC), requires prior authorization before any of this would be approved. During the prior authorization review, the reviewer for AHIC asked Joan's endocrinologist to explain why the prescribed interventions were medically necessary. The endocrinologist stated that Joan's condition was worsening and that the prescribed interventions were needed to stabilize Joan. The reviewer approved the claims.

Insurer Coverage of Bipolar Disorder Treatment
Jane has bipolar disorder and sees her psychiatrist once every three months for evaluation and to manage her medications. Jane sees her psychologist once a week for talk therapy consisting of cognitive behavioral therapy. Jane had been hospitalized three times previously because either a major depressive episode with suicidal ideation or an acute manic episode with psychotic features. Jane's psychiatrist noticed during her most recent visit that Jane demonstrated elevated mood, pressured speech, and explained how she had spent $4,000 the previous weekend on a spontaneous trip to Miami. Jane's psychiatrist feared that Jane was in the early stages of a manic episode, prescribed an increase to her dosage of lithium, recommended that she see the psychiatrist weekly for the next month, and that she see her psychologist twice weekly for the next month. Jane's insurance plan, operated by the Acme Health Insurance Company (AHIC), requires prior authorization before any of this would be approved. During the prior authorization review, the reviewer for AHIC asked Jane's psychiatrist if Jane was actively suicidal or psychotic. Jane's psychiatrist said no, but that a similar manic build immediately preceded each of Jane's previous hospitalizations up. The reviewer denied the claims on the grounds that they were not medically necessary because Jane was not actively suicidal or psychotic.